CALIFORNIA HEALTH BENEFIT EXCHANGE BOARD

July 22, 2011

East End Complex
Auditorium
1500 Capitol Ave
Sacramento, CA 95814

MINUTES

Agenda Item I: Call to Order, Roll Call, and Welcome

Chairwoman Diana Dooley called the meeting to order at 10:07 AM.

Board Members Present:	Kimberly Belshé Diana Dooley Paul Fearer Susan Kennedy
Board Members Absent:	Robert Ross, MD

Agenda Item II: Approval of the June 28, 2011 Minutes

Chairwoman Dooley presented the minutes to the Board for approval and asked for a motion to approve them.

Presentation: California Health Benefit Exchange Board June 28, 2011 Minutes

Discussion: None.

Motion/Action: Ms. Belshé moved to approve the June 28, 2011 minutes. Mr. Fearer seconded the motion.

Public Comment: None.

Vote: Roll was called, and the motion was approved by a unanimous vote.

Agenda Item III: Election of the Chair

Chairwoman Dooley asked the Board to defer this item until the August meeting so that Dr. Ross could be present and vote. The Board unanimously agreed to defer the election.

Agenda Item IV: Report from the Acting Administrative Officer

Patricia Powers, Acting Administrative Officer of the California Health Benefit Exchange, provided an update of activities since the June 28 Board meeting. Ms. Powers said that the Level I Establishment grant was submitted on June 30 and a budget negotiation call with federal representatives would take place during the next week. She said the Exchange had begun hiring staff and consultants, including Dennis Gilliam, Irma Michel, and Yolanda Richardson, noting that Ms. Michel and Ms. Richardson would be working on eligibility and enrollment (EE) business processes and policies.

Ms. Powers discussed the near-term deliverables on EE, noting that staff plan to present EE business process options in September and request a Board decision in October. The Board decision will inform development of an RFP for Exchange information technology systems with the aim of beginning to build those systems in early 2012. Ms. Powers noted that two pathways were created to manage and provide input to this effort. The first is an IT path consisting of partnerships between DHCS, OSI, MRMIB, and the Exchange; seven IT consultants are being hired to assist with scanning innovator states, reviewing federal requirements, and conducting a market research vendor questionnaire. The second pathway involves a joint effort with DHCS and MRMIB and the Exchange to solicit stakeholder input on business processes. The two pathways will dovetail in September, allowing staff to craft conceptual design scenarios to present to the Board that month. Ms. Powers described the formation of two stakeholder workgroups, one focused on EE issues related to individuals and one focused on EE employer-relevant issues for the SHOP. She pointed Board members to the stakeholder categories and list of participants that were included in the binders. Members of the public who are not workgroup members will be afforded the opportunity to listen in to the meetings and may submit comments at any time to eestakeholdercomments@hbex.ca.gov for consideration. Further, each workgroup member serves as a representative for his / her stakeholder category, so other stakeholders should feel free to contact these people. Lastly, Ms. Powers noted that staff continues to be involved in the User Experience 2014 Project to provide input on the national prototype design of the portal.

Ms. Powers said that the Exchange would be contracting with a policy expert to work with Gabriel Ravel, Staff Counsel, California Health Benefit Exchange, to develop comments on recently promulgated federal Notices of Proposed Rulemaking (NPRM) for exchanges. This person, along with Mr. Ravel, will reach out to other state departments and stakeholders for their thoughts on the proposed regulations. Staff will report back to the Board on the development of the proposed comments and solicit Board member input as appropriate at the August and September Board meetings. Comments are due to the federal government by September 28. Ms. Powers stated that staff is targeting August 18 as the final date for stakeholders to submit comments.

Ms. Powers briefly summarized the regulations that were released on Exchanges and reinsurance, risk corridors, and risk adjustment.

> **Public Comment:** Beth Capell, Lobbyist and Policy Advocate, Health Access, said that she appreciated the Board being welcoming of stakeholder feedback and taking action to

stop the misleading Exchange website. She noted that a law the Department of Managed Health Care uses could provide a model for avoiding similar situations.

Mr. Ravel presented a draft Conflict of Interest (COI) code to the Board. Under the Political Reform Act, every state entity must adopt a COI code and submit it to the FPPC for approval.

Presentation: Draft Conflict of Interest Code for the California Health Benefit Exchange

Mr. Ravel noted that, based on guidance from the FPPC, the COI code was drafted to require disclosure of income, gifts, and travel payments only from entities and individuals that the Board and staff members may foreseeably affect through their official duties. Mr. Ravel stated that the COI code could be voted on today or tabled for later.

Discussion: Mr. Fearer asked administrative questions about the COI provisions and their relation to the Form 700, which Mr. Ravel answered. Ms. Kennedy asked about prohibited gifts versus disclosed gifts. Mr. Ravel stated that any gift of $420 or more from a disclosable source is prohibited and any gift of $50 or more must be disclosed but only from disclosable sources.

Ms. Belshé asked for clarification on the disclosure of travel payments. Chairwoman Dooley suggested that staff return at the August Board meeting to provide answers to the specific questions raised by Board members. Ms. Belshé agreed with Chairwoman Dooley's suggested August postponement.

Chairwoman Dooley asked for public comment and saw none. She asked the Board members if there were any conflicts of interest that needed to be reported and saw none.

Agenda Item V: Search/Recruitment Subcommittee Status Report

Mr. Fearer presented the Search/Recruitment Subcommittee status report, noting that much work occurred since the last report. He said the subcommittee reached out to over 80 contacts for interest and candidate referral, noting that six candidates are slated to be interviewed. Mr. Fearer discussed the timeline, saying that the Committee is aiming to have the Board interview two candidates in closed session at the August Board meeting and ideally come to consensus on a selected Executive Director. He said that the Board will receive the analysis of the Towers Watson salary survey in August and hopes to announce it as well.

Agenda Item VI: Strategic Visioning

Ms. Powers introduced the strategic visioning presentation, noting that this would be the first of a three-part process that will lead to selection of vision and mission statements at the September Board meeting. She said that the speakers would present and discuss the CHCF vision papers and introduced the public opportunity to provide feedback in person and through the info@hbex.ca.gov email address.

The strategic visioning process began with a presentation of four exchange models: price leader, service center, change agent, and public partner. The models were developed to highlight the benefits and tradeoffs of specific strategic orientations.

Presentation: Models for the California Health Benefit Exchange – Wise, Chelius Hwang, Hoo, and Perrone

Price Leader: Lori Chelius, health care consultant, presented the Price Leader model. Ms. Kennedy asked about details on brokers in this model and if they drive down costs. Ms. Chelius responded that although they were not explicitly discussed, their role would need to be examined and noted that, although it was not her personal view, brokers add additional fees and thus would need to be addressed in this model.

Ms. Belshé asked how the Board could structure the model to get at the underlying costs. Ms. Chelius said that addressing this issue would relate to the short-term versus long-term vision and the realistic role of the Exchange, noting that carriers could also play a role in addressing these underlying issues.

Ms. Kennedy asked about consumer choice in the model. Ms. Chelius responded that the Price Leader model assumes less consumer choice. Ann Hwang, Wakely Consulting Group, said that at the Massachusetts Connector, when consumers make apples to apples comparisons of health plans, they tend to be very price conscious. Chairwoman Dooley asked about the consequences of choice and if this assumes that the Exchange will be a price setter. Ms. Chelius said that the Price Leader model assumes a very active purchaser. Nancy Wise, health care consultant, noted that the model wouldn't set rates but would have a competitive bidding process to determine prices.

Public Comment: Ms. Capell commented that the paper did not account for the natural population of the Exchange that receives subsidies. She asked how skimping on service would attract higher income people who don't receive a tax credit and the result on other Exchange users. Ms. Chelius said that the model wouldn't skimp on service but would focus on lean operations with an emphasis on efficiency, noting, however, that there are tradeoffs involved.

Julieanne Broyles, Legislative Advocate, California Association of Health Underwriters, commented that the noted commission for brokers is actually much lower and asked where the presented number was from. She said that, in regards to an analogy about airline kiosks, brokers and agents help consumers more directly and are more service-oriented. Ms. Chelius said that the commission figure is an historical figure and that the main point with the Price Leader model is that it focuses on price/costs specifically. She said that, in regards to the kiosk analogy, an important part of balancing the vision is in providing automation efficiently and in-person support effectively.

Gil Ojeda, Director, California Program on Access to Care, noted that California has experience rolling out big programs that are focused on cost and asked to what extent the paper looked at that experience. Ms. Wise said that one component of the paper noted the experience the state has as important for the Board to leverage, but it does not go into

great detail as it is not an operational plan. Mr. Ojeda observed that it would be important for the Board to look at this experience.

David Ford, California Medical Association, said that the CMA believes that narrow networks, which were mentioned as a strategy for the Price Leader model, could have the opposite effect of driving costs down. Ms. Chelius responded that traditionally, health plans offer extensive provider networks and the Price Leader model looks at every opportunity to lower costs, including network size.

Service Center: Ms. Hwang presented the Service Center model. Chairwoman Dooley asked Ms. Hwang, with her experience working at the Massachusetts Connector, about lessons learned. Ms. Hwang said that apples to apples comparisons are very important, along with a broad range of support. Chairwoman Dooley noted that the Connector was up and running in six months and asked, with the lead time for implementing the Exchange, what suggestions could be made. Ms. Hwang said it would be helpful to work closely with carriers to determine if there are more efficient ways to transmit data, along with streamlining transmissions between different entities.
Ms. Belshé asked if, with the Service Center model, outstanding service can overcome the price of health care. Ms. Hwang said that the model doesn't fundamentally change the price structure, but as it brings in more consumers and develops market leverage, it could play a role in affecting the price of health care.

Ms. Kennedy asked about data from the Connector that would show what expanded the number of enrolled consumers. Ms. Hwang answered that she did not know of any data that examined this, but noted that in the subsidized Commonwealth Care market in Massachusetts, there is some evidence that maintaining low prices is important. Ms. Kennedy asked about consumer satisfaction data and Ms. Hwang said a report was just released on a number of issues but only had data from Commonwealth Care.

Public Comment: Ms. Capell commented that Health Access prefers this model for the Exchange but sees it as a minimum, asking about retaining both subsidized and unsubsidized populations. Ms. Hwang said that it is important for the Exchange to get as many people as possible, both subsidized and unsubsidized into the program.

Micah Weinberg, Senior Policy Advisor, Bay Area Council, noted that it seemed like the hope is to get people into the Exchange and then create price changes, asking if, based on Ms. Belshé's question, market forces will affect the price or is it only possible through the procurement strategy. Ms. Hwang said that the Service Center model is based on customer service but noted that consumers are price sensitive.

Change Agent: Emma Hoo, Director, Pacific Business Group on Health, presented the Change Agent model. Chairwoman Dooley asked about Navigators and whether they were envisioned to play a broader role as health educators. Ms. Hoo answered that they could play both roles, helping consumers access insurance and access care.

Ms. Kennedy asked if the model, if implemented exactly as envisioned, would result in a net cost increase or decrease. Ms. Hoo said it would result in a decrease, noting there

may be some cost shifts, but that the goal would be to moderate trends and reduce costs. Ms. Kennedy asked about the drivers of those costs and Ms. Hoo said that using high value providers and streamlining for less duplication, less emergency room treatment, and more efficiency, could result in lower costs.

Ms. Belshé noted that expanding existing provider capacity was addressed in the model and asked how the Change Agent model advances that and the timing of expanding existing provider capacity. Ms. Hoo said it was a near-term goal and cited Boeing as an example of introducing high quality health plans with case managers, thus giving primary care physicians more time to treat patients efficiently.

Public Comment: Elizabeth Landsberg, Legislative Advocate, Western Center on Law and Poverty, commented on the roles of Navigators, asking if Navigators would also do outreach. Ms. Hoo said that health fairs used during open enrollment periods provide opportunities for outreach but said that year round outreach is necessary.

Ms. Capell asked about reconciling the fact that the uninsured tend to go in and out of coverage with the vision of long-term case management. She also asked about prevention and opportunities for integrating a public health perspective into the model. Ms. Hoo said that if the best care and service are provided then it will bring an amount of "stickiness" to coverage, noting that better data interchanges will help with case management as well. She said that there is an opportunity to promote preventive services and self-care with incentives. Ms. Capell noted that it's important to be careful with incentives because there isn't a lot of data showing that they work effectively.

Julie Silas, Senior Policy Analyst, Consumers Union, noted that there are lots of metrics for providers and asked if there are metrics for other parts of the system. Ms. Hoo gave an example, saying that data shows satisfaction rates dip when out-of-pocket costs are increased. She said there needs to be more detailed data so that those metrics can be meaningful to consumers, acknowledging that this lack of data is a missing layer.

Mr. Ojeda commented that the Change Agent paper acknowledges the diversity of California and he called attention to a report noting that consumers are a part of the process. He noted the State Health Workforce Development Council as another resource examining workforce capacity.

Casey Young, Associate State Director for Advocacy, AARP, commented on adverse selection but noted that Ms. Hoo had said that there would be a net decrease in costs, asking how those two things interact. Ms. Hoo said that the experience with PacAdvantage shows that pre-existing conditions can play a role in adverse selection, noting that if one plan includes a cancer center it will draw more people with cancer than other plans. Ms. Hoo cited Kaiser as an example of good adverse selection management through their use of good customer service and effective preventive care, saying that effective management can reduce cost.

Michael Johnson, Senior Public Policy Advisor, Blue Shield of California, asked about the levers the Exchange can apply to create delivery system reform, asking specifically about disclosure. Ms. Hoo said that the Change Agent model fully supports a higher degree of transparency, noting that health plans use quality ratings to attract consumers, and having more fully disclosed information at all levels would help consumers make even more knowledgeable decisions.

Cary Sanders, Director of Policy Analysis and the Having Our Say Coalition, California Pan-Ethnic Health Network, commented on her excitement about the possibility of providing care to ethnic populations, noting references to having primary care physicians in communities without them and using Navigators as health educators. She asked about Board oversight and the potential and risks associated with the model. Ms. Hoo said that ensuring the consistency of services and ensuring certain competencies would be important, noting that the model would require careful management to be successful.

Public Partner: Chris Perrone, Deputy Director, CHCF's Health Reform and Public Programs Initiative, presented the Public Partner model. Mr. Fearer asked about other public and quasi-public entities such as CalPERS, the UCs and CSUs and why they weren't discussed in the model. Mr. Perrone said that the model needs to be concrete and thus the focus is on Medi-Cal, but noted that there are tradeoffs to collaborating with other programs as well, because it's easier to lose focus on specific goals.

Ms. Belshé noted the array of contracting options in the Public Partner model and asked if they were transferrable or unique to the model. Mr. Perrone said that a broad array of health plan choice and apples to apples comparisons for consumers are doable across all models while incentivizing plans to join Medi-Cal is unique to the Public Partner model because the focus on this type of incentive is most appropriate with a public partner model.

Public Comment: Ms. Landsberg commented that the Public Partner model makes a lot of sense and noted that in doing outreach it's hard to know about income level.

Ms. Capell said that she had the same question as Mr. Fearer but noted that it was disturbing to her that one would suggest that the state discourage enrollment during state budget crises. Mr. Perrone said that the reality of the state budget process is that funds have historically been withdrawn from outreach during a crisis. Ms. Capell said that with health care reform, people have a right to health care and thus, it is disturbing to think that it would go away during budget crunches.

Alison Lobb, Project Coordinator/Analyst, California Coverage and Health Initiatives, commented that children's access to health care needs to be a focus in low-income populations.

Board Discussion: Ms. Belshé asked about the size of the Exchange and if the models are compromised if the core population is smaller. All the presenters said that size was

important to the success of the models, but Ms. Wise noted that there was no consensus as to whether two million lives was enough to incentivize change.

Break for Lunch (12:45 PM)

Meeting Called to Order from Lunch (1:20 PM)

Agenda Item VI: Strategic Visioning (cont)

Bobbie Wunsch, Facilitator, California Health Benefit Exchange, introduced the strategic visioning session, explaining the process to the Board and members of the public. The first question was "How will we know if we're successful, in the near-term and the long-term?"

Ms. Kennedy said that affordability is the main determinate of success. She noted that this may mean arresting costs compared to today, or reducing costs in the future. She said that if the Exchange costs the General Fund money, then the Board will have failed.

Ms. Belshé said that the public expectation is to see progress in reducing the number of uninsured. She stated that she hoped the Exchange would also use metrics on coverage, enrollment, access, and quality, noting that while the near-term measure of success would revolve around price and enrollment, they are only part of the overall success.

Mr. Fearer echoed the opinions of the other Board members and said that for customers, the Exchange should be trusted and reliable. He noted that cost is important while at the same time improving quality.

Chairwoman Dooley said that near-term success entails providing insurance on January 1, 2014. She noted that due to the issues at the federal level there could be serious challenges to that measure of success. Chairwoman Dooley said that long-term success would come from changing the fundamental concept of expectations for health care delivery and what it provides. She stated that the change agent model resonates the most for her.

Mr. Fearer stated that near-term, the operations of the Exchange need to be delivered accurately, efficiently, and promptly.

Ms. Kennedy stated that while quality will be a metric of success of health care reform, the Exchange is narrowly defined and the Board must focus on this to succeed in the short term. Ms. Kennedy noted that while the Board should take advantage of the opportunities to improve quality when they are available, if they did not remain focused then it could be a failure.

Ms. Belshé noted that while Ms. Kennedy's point relates to the absolute requirements of the Exchange that need to be completed by 2014, there are other long-term goals, stating that the Board's goals could look different years from now. She said that, in regards to

the models, all of them resonate in that the Exchange needs to provide a piece of each model. Ms. Belshé stated that, in the near-term, the Exchange needs to be a price leader with excellent customer service.

Mr. Fearer said that, in response to Ms. Kennedy's point about broad health care reform versus the narrow focus on the Exchange, these aren't irreconcilable except for the time dimension. He noted that it is, however, important for the Board not to make decisions in the short-term that prevent it from taking advantage of the long-term possibilities.

Chairwoman Dooley noted that people sometimes believe health care reform and the Exchange are synonymous, when in fact the Exchange is just one part of health care reform. She said that the Exchange's role is to be an efficient, transparent marketplace for coverage while noting that coverage itself doesn't lead to health care reform.

Ms. Wunsch stated the second visioning question, asking the Board "What words describe your vision for the Exchange?"

Chairwoman Dooley said that, relating to her last statement, she hoped efficient would mean usable, stating that she did not want so many options that people become overwhelmed.

Ms. Kennedy said the words cost-efficient and value-based describe her vision for the Exchange.

Ms. Wunsch stated that the Board could add Mr. Fearer's word "trusted" to the list as well.

Mr. Fearer stated that he wanted to underline value, noting that price also needs to include quality. He said that he felt some things were not fully captured during the last question, such as first class customer experience, and he wanted to make sure that was included.

Ms. Belshé used the word consumer-focused, noting that this term is often discussed in regards to the delivery system, but all processes, including eligibility and enrollment and outreach and education, need to be focused on the consumer.

Mr. Fearer said that Ms. Belshé's point relates to the broad issue of information. He said it's critical for the Exchange to get the consumer the right information, at the right time, and through the right channel. Mr. Fearer also noted that collaboration needs to occur with other purchasers and entities, not just Medi-Cal and the Health Families Program.

Ms. Wunsch recapped what the Board had discussed during the first two questions. She stated the third question, asking "What guiding principles do you suggest for the Exchange?"

She said that she hoped a guiding principle would be putting the consumer at the forefront of everything the Board does because the main goal of the Exchange is selling

insurance. She noted that the fundamental principle of the Exchange is to sell insurance but this does not occur in a vacuum. Mr. Belshé acknowledged that the focus on the consumer is not to occur to the detriment of other activities.

Mr. Fearer said that there needs to be a commitment to consistency in affordability, accessibility, and quality across the entire geography of California.

Chairwoman Dooley noted that the Exchange is not selling insurance but rather is a clearinghouse or marketplace for people to buy insurance. Ms. Belshé agreed with this assessment. Chairwoman Dooley stated that a principle for her is moving to self-reliance, explaining that it relates to her interest in personal responsibility for health, through prevention and other means, so that people are informed and can make their own decisions. She said that the Board shouldn't think in terms of "we know better" but rather should provide a place to give people information so they can make an educated choice. Chairwoman Dooley stated that insurance is a means to an end, noting that while having coverage is important, it doesn't always result in care and therefore it is an individual's personal responsibility to seek care. She said that personal responsibility is a principle for her.

Chairwoman Dooley also noted goals of the Exchange were already laid out in the federal and state laws creating health care reform and the Exchange.

Ms. Kennedy noted that a guiding principle is fidelity to the task given, under federal law and specifically state law.

Ms. Belshé said that personal responsibility could be a personal value and could become an Exchange value if it manifests itself through the policy decisions of the Board. Ms. Belshé said she wanted to articulate transparency and information from both a consumer and provider perspective.

Ms. Kennedy asked to challenge the difference between personal values and guiding principles, stating that while she supported personal responsibility as a value, if she found that it was incompatible with the success of the Exchange then it would immediately be removed. She said that the principles have to be good for making the Exchange work.

Public Comment: Gloria Fauss, Political Director, SEIU-UHW, commented that she didn't feel like there had been discussion of keeping costs down but acknowledged that it may have been discussed earlier when she was not present.

Agenda Item VII: Pending Legislation

Chairwoman Dooley noted that she was contacted by many people prior to the Board meeting regarding staff recommendations on pending legislations. She reminded the public that the Board operates under the Bagley-Keene Open Meeting Act, which prevents Board members from discussing matters that may come before the Board outside of public meetings. She stated

that the public should not expect a response to inquires about Board members' positions on agenda items.

Chairwoman Dooley noted that the agenda indicated action on legislation but said that the Board was not required to take one if they so decided. She said she would abstain from any votes on legislation because the Administration hasn't taken positions on pending legislation.

Ms. Powers said that staff received letters from stakeholders regarding legislation and distributed them to the Board members. She noted that the legislation discussion stemmed from requests by Ms. Belshé and Ms. Kennedy and said that staff is seeking direction from the Board on any actions taking regarding legislation. Ms. Powers said that while staff appreciates the intent behind the bills, staff is waiting for federal guidance on many of the issues raised in the proposed legislation. In addition, the Level I grant application includes many of the processes with stakeholders and others that are laid out specifically in the bills.

Assembly Bill (AB) 52: This bill would require a health care services plan or health insurer to receive approval from the Department of Managed Health Care or the California Department of Insurance prior to implementing any new rate or rate change in the individual or small group market beginning January 1, 2012. Staff recommended that they work with the author's office to gain an exemption from the provisions of the bill.

Presentation: Bill Report – AB 52

Discussion: Chairwoman Dooley said she'd been contacted by Insurance Commissioner Dave Jones asking to make a presentation at the August Board meeting. Chairwoman Dooley stated her preference that Board discussions of pending legislation be limited in scope to the affect on the legislation on the Exchange. She noted that legislative hearings, rather than Board meetings, are the appropriate venue for advocating for and against legislation.

Ms. Kennedy asked how and when the Board would decide on their action and questioned the timing to make amendments. Joe Munso, California Health Benefit Exchange, responded that amendments could be made in mid-August. Ms. Capell said that floor amendments could occur in September.

The Board discussed whether they should be taking a support/oppose position or if it would be more appropriate to ask for amendments without a specific position on the entire bill. They decided to seek amendments where possible and not support or oppose bills entirely unless they deemed it necessary.

Ms. Kennedy asked how the Exchange could negotiate for prices if another entity would have the authority to amend those rates, saying it could be very disruptive. She also asked staff if they could comment on the Massachusetts rate regulation function relative to its impact on exchanges in Massachusetts.

Ms. Belshé said that timing is not clear on rate regulation and that it could affect Exchange negotiations, expressing concerns about the compatibility with the Exchange

and asking why Medi-Cal and the Healthy Families Program were exempted while the Exchange was not.

Katie Marcellus, Assistant Secretary, California Health and Human Services Agency, said, in regards to Ms. Kennedy's first question, that staff shared the concern over timing and noted she did not know about Massachusetts' situation.

Ms. Belshé said she agreed that the Exchange doesn't need to take a support/oppose position but did want to note concern over the impact of the proposed legislation on the Exchange, saying she agreed with the staff recommendation.

Mr. Fearer noted that there are other factors that impact the discussion of rate regulation including the impact of geography on premiums rating and forthcoming federal guidance.

Chairwoman Dooley and members acknowledged that they were all contacted by, and spoke with, the Insurance Commissioner prior to the Board meeting. In light of that fact, Chairwoman Dooley asked Mr. Ravel for guidance in responding to the public who ask individual Board members about items on the agenda. Mr. Ravel said that while there is little Board members can do to prevent such conversations from happening, members can keep the conversation one-sided and not reveal their position to prevent cross-communication outside of Board meetings. He said that a serial meeting or cross-communication, even if it was incidental, could invalidate a Board action.

Rita Saenz, Director of Communications, Affiliated Computer Services, asked for clarification on exactly what stakeholders can do when contacting Board members. Chairwoman Dooley and Ms. Kennedy explained that the public can talk to Board members individually but Board members cannot say anything back to them about their opinions to prevent cross-communication outside of public meetings.

Public Comment: Rebecca Marcus, Chief of Staff for Assembly Member Mike Feurer, requested that the Board not take a position, explaining that the legislation was meant to complement the Exchange. She noted that Mr. Feurer's office was convening stakeholder meetings and wanted to involve Exchange staff to get it right. She asked the Board to direct staff to work with the Assembly Member's office to make changes. Ms. Marcus discussed timing of amendments for the bill, noting that the deadline for floor amendments is September 2.

Janice Rocco, Deputy Commissioner of Health Policy and Reform, California Department of Insurance (CDI), asked the Board to defer a decision on exempting the Exchange from AB 52, saying that amendments regarding timing could provide a better option than complete exemption. She noted that products inside and outside the Exchange need to be the same and thus regulation needs to be the same, saying that while she appreciated the negotiating power of the Exchange it is not unfettered. Ms. Rocco said that, in Massachusetts, there are times that the Connector negotiates reasonable rates while sometimes the rates have to be lowered by the regulator, noting that there is a collaborative relationship and reiterating that staff should work with CDI to make AB 52

work with the Exchange. She said that the Medi-Cal and Health Families exemption language is consistent with existing statute and that the main difference between these programs and the Exchange is that they have a finite amount of money that is known by the insurers.

Ms. Belshé asked Ms. Rocco if AB 52 gives the Commissioner the ability to dig into the drivers of cost or if it assumes rates as they are today and then regulates them going forward. Ms. Rocco said that CDI looks at medical costs, utilization trends, administrative costs and profits, checks if projections line up with actual data, and then reviews or denies the rate increase.

Chairwoman Dooley suggested creating a subcommittee to look into the issue of rate regulation in more depth. Ms. Belshé expressed concern that a subcommittee would only work if there was an early August meeting due to the timing of legislation and said that if there's such an issue with Board members then they should use the staff recommendation, noting that she is not sure if the two authorities are compatible and that she agrees with the staff recommendation.

Ms. Capell commented that she respected the concerns raised by staff but said that the Exchange is much different from Medi-Cal and Healthy Families as a part of the private insurance market. She said that, in regards to looking at cost drivers, DMHC regulates most plans and existing law requires them to look at underlying costs, noting, however, that there are concerns with the timing and the process.

Julie Silas, Senior Policy Analyst, Consumers Union, noted that there is a difference between the Exchange and Healthy Families and thus a direct exemption would not be necessary.

Carla Saporta, Health Policy Director, Greenlining Institute, said that she wanted to make rate review work and did not want the Board to take the staff recommended action today.

Patrick Johnston, President and CEO, California Association of Health Plans, commented that AB 52 undermines the Exchange's power to decide costs, noting that premium rates in the Exchange will become benchmarks and that AB 52 will give DMHC and CDI the authority to veto Exchange decisions. He noted that AB 52 interferes with the ability of the Exchange to provide insurance on January 1, 2014, and noted the timing issues on appeals and others. Mr. Johnston said that AB 52 also creates a problem after 2014 regarding standardized products, noting that rate review on products outside the Exchange could create different rates than those offered inside and could allow for rate suppression in the outside market, resulting in cost shifts.

Pedro Morillas, Consumer Advocate, CalPIRG, said CalPIRG is a strong supporter of AB 52 and understands the concerns, but said that AB 52 needs to include the Exchange. He said he is concerned that if rate regulation isn't passed until the next session, health plans will take measures to avoid regulation. Mr. Morillas expressed his concern about adverse

selection and wanted the Board to work with the author to be involved with rate regulation and not be exempt.

Bill Wehrle, Vice President, Health Insurance Exchanges, Kaiser Permanente, said that rate regulation will prevent health plans from trusting the rates negotiated with the Exchange as they may be changed by regulators. He said that there are cost shifting concerns if rates are held artificially low outside the Exchange, noting that if the Exchange is exempt then Exchange products offered outside the Exchange should have the same exemption.

David Chase, California Outreach Director, Small Business Majority (SBM), said SBM supports AB 52 but has concerns about its impact on the Exchange. He noted that the author has shown a willingness to be pragmatic and that, while there are concerns about the Exchange not being fully exempted, the Board should work with the author to find a compromise.

Motion/Action: Ms. Kennedy moved to follow the staff recommendation. Ms. Belshé seconded.

Vote: The roll was called, and the motion was approved by a 3-0 vote, with Chairwoman Dooley abstaining and Dr. Ross absent.

AB 714, 792 and 1296: These bills would require various eligibility and enrollment notifications regarding the availability of coverage through the Exchange and would establish various eligibility and enrollment processes. Staff believed these bills to be premature given pending federal guidance and planned collaboration with stakeholder partners to discuss eligibility and enrollment policies and notifications.

Presentation: Bill Report – AB 714
Presentation: Bill Report – AB 792
Presentation: Bill Report – AB 1296

Discussion: Ms. Belshé said that while all three bill as consistent with the big picture perspective prepopulating the Exchange she agreed with the staff recommendation that they're premature. She said she did not see what had to be done this year and noted that the current stakeholder process could bring different approaches than those laid out in each bill.

Mr. Fearer said that while the bills feel well-intended, there's a lot of complexity to the issues and he feels the time pressure of the legislative calendar. He noted that it's not clear why these are so urgent and asked why some processes need legislation while others the Exchange is already performing without legislations.

Ms. Belshé said that another consideration would be in areas that federal guidance is still required.

Public Comment: Ms. Capell commented that California didn't wait for Exchange guidance to create the Exchange and noted that there's a lot of work to do for the Exchange in 2012, expressing worry that there's too much. She said Health Access appreciated the kind words on the intent but that they would be moving forward with these bills. She said, for AB 714, that if it's not done this year then it won't be law until 2013 and there will be plenty of misinformation in 2012. She said, for AB 792, it will give the Exchange more time to work with regulators if passed in the current legislative year.

Ms. Kennedy noted that Ms. Capell's comments inferred that the Exchange was simply waiting and said the Exchange is concerned about creating two processes for the same thing. Ms. Capell said that the bills don't preempt the Exchange but provide auto-applications so people are sent to the Exchange.

Ms. Landsberg commented that AB 1296 is Western Center on Law and Poverty's bill. She noted that the Exchange had stated its intent to use a vendor and said it is important to get AB 1296 passed before working with the vendor. She said that she appreciates participating in the eligibility and enrollment stakeholder workgroup but said the process needs to move up.

Ms. Belshé said that the issue revolves around how to align the two paths, noting it's hard to reconcile the work staff is doing with the stakeholder workgroups with what's going on with legislation. Ms. Kennedy stated that with all due respect the stakeholders were proposing to do the Exchange's work for them.

Ms. Sanders commented that it was never too early to get information out to communities of color, noting her concern that the Exchange will need as much time as possible to do this. Regarding AB 1296, she said that it provided authority to move forward, saying that if the stakeholder process can be used to inform the requirements of the bill then that's helpful.

Steve Dixon, Grassroots Organizer, Consumers Union, noted his support for what other speakers had said.

Ms Belshé said that she appreciated the notion that it's never too early to get information to consumers but is concerned that the urgency is not necessary and that getting into this level of specificity could be detrimental and federal enrollment and eligibility guidance is imminent. She said she wanted staff to move forward with the stakeholder process and get it right, noting that the bills feel very prescriptive.

Motion/Action: Ms. Belshé moved to follow the staff recommendation. Ms. Kennedy seconded.

Vote: The roll was called, and the motion was approved by a 3-0 vote, with Chairwoman Dooley abstaining and Dr. Ross absent.

AB 1083: This bill would conform state law to certain provisions of the ACA but would prohibit premium surcharges for cigarette use and premium flexibility from health/wellness incentives, which are permissible under ACA. Staff recommends working with the author to allow some limited premium flexibility in the area of prevention and wellness incentives with appropriate protections against insurer and employer discrimination.

Presentation: Bill Report – AB 1083

Discussion: Ms. Kennedy asked why the extra provisions were necessary. Ms. Powers said they were the result of concerns over the equity of premiums for low-income people. Ms. Kennedy said she would like to support the bill but was concerned about taking out the wellness incentives.

Public Comment: Mr. Chase noted that Small Business Majority is a co-sponsor of this bill and said that while they are strong supporters of wellness incentives, there is not a consensus on how to do it effectively. He said that they should be allowed under the proper circumstances and hoped the Board supported the legislation as it is now and went back for cleanup legislation later.

Ms. Kennedy asked Mr. Chase if he was suggesting that the Board be prevented from negotiating with insurers over these things and then go back to get legislation to allow that. Ms. Chase said that because there's no consensus on wellness incentives and tobacco discounts, that's what the Board should do.

Ms. Capell said that an earlier version had wellness incentives included, but it was removed because it is a contentious issue, noting that Health Access opposes wellness incentives for a variety of reasons. She said the issue would come up again next year.

Nick Louizos, Director of Legislative Affairs, California Association of Health Plans, commented that CAHP opposes unless amended and reflects the Exchange staff's recommendation. He said that they would like to see a straight conformity bill.

Ms. Sanders commented that there are concerns about wellness incentives relating to health conditions among communities of color, noting that people with health conditions will end up subsidizing the market for those without.

Motion/Action: Ms. Belshé moved to follow the staff recommendation but wants to include working with the author for flexibility on both prohibitions or make it a two-year bill. Mr. Fearer seconded.

Vote: The roll was called, and the motion was approved by a 3-0 vote, with Chairwoman Dooley abstaining and Dr. Ross absent.

SB 703: This bill requires MRMIB to establish a Basic Health Program (BHP). Staff states that additional analysis and federal guidance are necessary before deciding whether to establish a BHP.

Presentation: Bill Report – SB 703

Discussion: Mr. Fearer said he strongly agrees that it is premature to create a BHP at this time and noted that nearly all stakeholders are aware of the risk for adverse selection. Ms. Belshé said that one of the principle goals of the ACA is affordability and continuity of coverage, but noted there are concerns regarding the BHP's impact on the Exchange. She said it gives her pause and thus she would like staff to work with the sponsors and the authors to figure out options. Ms. Belshé noted she is concerned that it would add extra transitions that could negatively affect the Exchange.

Ms. Kennedy said that the Board's task is already difficult and that all the bills prescribing how to do the work, especially SB 703, make it even harder for the Board to do its work. She said due to a lack of understanding on how the BHP with truly effect the Exchange, she would want to oppose unless it's clear that it will help the Exchange.

Public Comment: John Ramey, Executive Director, Local Health Plans of California, said that health care reform and the Exchange are about providing economic security for low income working people so a health problem or accident doesn't lead to economic ruin, noting that a BHP in California would provide coverage to people for much lower prices, resulting in state savings and higher take-up rates. He said that the Exchange and BHP should work together to create more affordability and get more people into coverage. He noted that there will be more churning between 133% and 199% of FPL and thus a BHP will be more helpful to that population than the Exchange. Mr. Ramey requested that the Exchange set off on a course of action to get the BHP done.

Ms. Belshé asked Mr. Ramey if he had thought about other approaches to affordability without peeling off one to two million people from the Exchange and asked if federal law precludes the Exchange from running the BHP. Mr. Ramey said that federal law did not preclude the Exchange from running the BHP but noted that the Board shouldn't delay.

Ms. Belshé asked, given the general timelines on federal guidance, why the BHP is necessary now. Mr. Ramey said that when he calendars backwards from a pre-enrollment date of July 1, 2013, giving all required participants the time to get prepared, it needs to happen in this legislative session.

Ms. Powers noted that she didn't agree with the timeline and asked why it needed to be ready in 2014. Mr. Ramey said that affordability is the most important reason and demands that California create a BHP.

Ms. Belshé said that she didn't feel that the Board has enough information to support a BHP if they can't consider tradeoffs between affordability for some and rate negotiations that affect the entire insurance market. She noted that the risks to the Exchange, such as

viability and market power, need to be called out. Mr. Ramey said that he couldn't understand how one could ignore the affordability of the BHP. Ms. Belshé noted that it comes down to timing, saying that if the Board can get more information between now and next year then they can make a more informed decision.

Mr. Fearer said with the Medi-Cal expansion and the Exchange, it seemed that Mr. Ramey was taking the current pricing as a given. Mr. Ramey said that in looking at the Exchange and the BHP, the BHP is closer to a public program and could provide affordability for consumers, while admittedly providing less provider choice, and give Medi-Cal providers a significant rate increase for this population.

Ms. Kennedy asked about the General Fund impact. Mr. Ramey said there will be a General Fund savings because Medi-Cal people could be moved to the BHP.

Ms. Landsberg said they support the BHP and while there are concerns about continuity and streamlining, they believe that the Exchange can continue to work effectively.

Anne McLeod, Senior Vice President, Health Policy, California Hospital Association, commented that they support the goals of the BHP but not the current version. She noted that the minutes from the May 11 Board meeting incorrectly stated that she supported the BHP but that they supported only the goals of the BHP.

Mr. Fearer asked if the position needs to be opposed or made into a two-year bill. Ms. Kennedy said that unless someone can show it won't negatively affect the Exchange, then the Board needs to oppose the BHP or amend it to be a two-year bill. Ms. Belshé noted that this discussion demonstrates the importance of giving staff clear direction and encouraged staff to work with the co-sponsors and authors to see what can be resolved, and sounds like that is to make it a two-year bill.

Motion/Action: Ms. Kennedy moved to oppose SB 703 unless it is made into a two-year bill. Ms. Belshé seconded.

Vote: The roll was called, and the motion was approved by a 3-0 vote, with Chairwoman Dooley abstaining and Dr. Ross absent.

Agenda Item VIII: Adjournment

The meeting adjourned at 4:02 PM.